State of Idaho
Department of Administration
Office of Insurance Management

Premium Only Plan Election Form

☐ Initial Request

☐ Change _____

☐ I want to participate in the State of Idaho Premium Only Plan and have my salary reduced by the amount I pay for group medical/dental benefits. I understand this may reduce my potential Social Security benefits. I realize I can change this election only during the election period prior to any plan year or if there has been a qualifying change in my family's status, employment, or group health care coverage.

☐ I decline to participate in the State of Idaho Premium Only Plan. I understand that I will not be eligible to change my election until the following plan year, unless there has been a qualifying change in my family's status, employment, or group heath care coverage.

Signature _____ Date _____

Employing Agency _____ SSN _____